Lisa A. Murawski LMHC PLLC
100 College Parkway Suite 255
Williamsville, NY 14221

Teletherapy Informed Consent Form

I hereby consent to engage in teletherapy, coaching or consultation services with my provider Lisa A. Murawski LMHC PLLC. I understand that "teletherapy" includes clinical consultation, treatment, transfer of medical/psychiatric data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching and consultation also involves the communication of my medical/psychiatric information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment however withholding or withdrawing consent may result in a delay of services.
2. The laws that protect the confidentiality such as HIPAA of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, these include:

   I. If you, in writing, require such disclosure;
   II. If child abuse or neglect is disclosed, your counselor is required to notify the appropriate State Department of Children and Family Services;
   III. If you seriously threaten or act in a way that indicates that you are very likely to harm yourself, your therapist may have to seek hospitalization for you, or call your family members or others who can help protect you. If such a situation does arise, they will fully discuss the situation with you before taking action, unless there is a strong reason not to for the purposes of safety.
   IV. If your counselor believes that another person is at risk of serious injury or death.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Lisa A. Murawski LMHC PLLC that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that if my provider believes I would be better served by face-to-face sessions, that will be scheduled.

5. I accept that teletherapy does not provide emergency services. During our first session, my provider and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. If I reside in Erie County, I can also contact Crisis Services at 716-834-3131 (for adults) and Spectrum Cares at 716-882-4357 (for children and adolescents).

6. I understand that I am responsible for
    a. providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions,
    b. the information security on my computer, and
    c. arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
7. I understand that while email may be used to communicate with my provider, confidentiality of emails cannot be guaranteed.
8. I understand that I have a right to access my medical/psychiatric information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

_____ _____ _____

Client (or Guardian's) Signature Date Provider Signature